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ABSTRACT

This document begins by dispelling several misperceptions about American Indians that are especially pernicious to older American Indians living in cities, and then goes on to discuss what is known about urban American Indian elders and the implications for planning and service delivery for Area Agencies on Aging and contractor agencies. It notes that the life expectancy and longevity of American Indians remains below that of the general U.S. population; that Title VI of the Older Americans Act was designed to provide support services to older American Indians living on reservations, but that nearly half of American Indians over age 25 live not on reservations, but in cities; and that the older Indian urban population should be served by Title III programs. Examples are given that illustrate why chronological age is not a clear indicator of health status in American Indians. Socioeconomic and health profiles of older urban American Indians are given. A small study on nutrition of urban elders is reported that shows that, although elderly urban American Indians do not suffer from malnutrition as their reservation peers do, they have below the recommended levels in total food energy, vitamin A, and calcium intakes. A low utilization of mental health services among elderly American Indians is discussed, and support services needed by urban American Indians are considered. Problems and solutions in providing services to this population are presented. Several relevant data tables are included. (NB)

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URBAN AMERICAN INDIAN AGING[1]

Josea Kramer, Ph.D.

Presented for ASA's Summer Series on Aging, Concepts and Issues: Minority Aging Populations, San Francisco, 1990

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A number of myths persist about American Indians and these are especially pernicious to American Indian elders who live in our nation's cities. Let me dispel the misperceptions first and then go on to discuss what is known about urban American Indian elders and the implications for planning and service delivery for Area Agencies on Aging and contractor agencies.

1. **When American Indians get old, they retire to reservations.**

   The vast majority of elders do not return to reservations. For over a decade, American Indian organizations have produced local reports--unfortunately with narrow dissemination-- noting that their elders have aged in place and that no services seem to be available in recognition of that fact. From my conversation with AAA planners, this misperception has hindered both research on the needs of this population and serious planning efforts to fill these needs.

2. **American Indians are eligible for special services because they are wards of the government.**

   All American Indians are US citizens and they are not wards of the governments. There is a unique and special relationship between the federal government and tribal entities. This trust relationship recognizes American Indian societies as self-governing "domestic dependent nations" and the federal government as having fiduciary responsibilities for land title and social services.

   However, these services may be linked exclusively to the reservation and the sovereign tribal government. Health care is a good example. After a period of 120 days residence off-reservation, an American Indian is no longer eligible for medical care by Indian Health Service. The federal responsibility is transferred to state public health departments. Urban American Indians have long been turned away from health clinics by providers who misunderstand the federal regulations and tell Indians to get their service from IHS.

   As citizens, American Indians are taxpayers. Although on federal Indian reservations state tax doesn't apply for the same reasons as on federal military reservations.

3. **Title VI of the Older Americans Act is designed to serve American Indians and therefore Title III providers have limited responsibility to serve older American Indians.**

The most recent reauthorization of the Older Americans Act clarified that issue with specific wording that area plans consider the number of Indians residing in the area and, if a significant population of American Indians lives in the area, to conduct outreach to those individuals.

All Title VI programs are limited to reservations and are contracted with tribal entities. There are 278 reservations and 209 Alaskan Native Villages and 81 Title VI programs. Obviously the majority of elders living on reservations are not in a position to receive Title VI services, which are by the way mostly limited to nutrition.

But the majority of the American Indian population does not live on reservations. Nearly half of the American Indians over age 65 live in cities and, from the perspective of OAA services, should be served exclusively by Title III programs.

4. **American Indians are a homogeneous culture.**

Popular images of American Indians tend to mix together elements of different indigenous cultures and most Americans are unaware of the great diversity of American Indian cultures. Despite the effects of conquest and participation in the dominant U.S. society, 150 distinct American Indian languages continue to be spoken today. Cultural understandings underlie perceptions of appropriate behaviors. For instance, while elders were universally respected, there were/are tremendous differences in the way treatment of frail elderly.

In the 1970's urban American Indian organizations and national Indian organizations forged a pan-Indian identity which recognized their shared concerns as native peoples despite their cultural differences.

With some of the most common misperceptions laid to rest, let's go on.

Older urban American Indians are a little known population. Most of the literature on urban American Indians examined their adjustment to city life in the period 1950 - 1970. This was a period of great migration from rural reservations to cities, a migration underwritten by relocation programs which were part of the federal policy to terminate the special relationship with the tribes. Research conducted in that period concentrated on the negative impact of urbanization: crime, alcoholism, unemployment, maladjustment. No doubt, equal emphasis was not given to successful adaptive strategies because funding was generally tied to solving social problems.

In any case, the impression given to an unwary reader is that American Indians are unable to establish themselves in urban areas. For many relocatees this was true. Early in the program the rate of return to reservations was 75% and this later dropped to 35%. Even given the high return rate of those who were not highly motivated to live in cities, the percentage of American Indians living off reservations jumped from only 7.2% in 1940 to 50% in 1977.

The literature also notes that older American Indians are less successful at adjustment and more likely to return to their reservations. After considerable research, I located the documents which define "older" in that context. An older American Indian was someone over either age 25 or age 30 depending on analysis. Those younger individuals who did adjust and did remain in cities over

the last 40 years are now at retirement age. Whether in Phoenix, Los Angeles or San Diego, when asked, elders reported that they did not plan to return to their natal reservations. In fact, age was associated with an increasing commitment to remain in the city in our L.A. survey. (FIGURE 1).

The life expectancy and longevity of American Indians remains below that of the general US population although those rates have shown improvement since World War II. The average life expectancy of American Indians is eight year less than non-Indians. Title VI of the Older Americans Act recognizes the need to provide support services to older American Indians living on reservations who may not yet be 60+. That waiver is not extended to elders living in urban settings.

Chronological age is not a clear indicator of gerility in American Indians. The National American Indian Council on Aging using the OARS instruments on a national sample, found that American Indians at middle-age suffered impairments which are characteristics of the general US population aged 65+. On reservations, individuals appeared aged at 45+ years and in urban areas, American Indians were aged by 55+ years. In Los Angeles, the median age for both men and women who were considered elders by the community was 58 years.

Indeed, American Indians do not define aging by chronology. The American Indian community both on and off reservations uses social role functioning (e.g., grandparenting) and decline in physical activities as indicators to define which individuals are

considered "elders". Treating elders according to their abilities is rooted in cultural practices. The notion of calendar date birthdays and attendant celebrations of life stages was only introduced during the reservation period. This notion of aging has not been accepted as normative. Based on the differing expectations of the aged, eligibility criteria for social service programs (e.g., JTPA, poverty programs) bear reevaluation.

SOCIO-ECONOMIC PROFILE

The 1980 U.S. Census most certainly under-counted American Indians. The enumeration does indicate a population in great social and economic need. No where in the U.S. did the income of urban American Indians age 65+ equal that of whites. Approximately one third of urban American Indians have incomes below or slightly above (25%) the poverty level in contrast to one fifth of whites who live at that level of poverty. Despite the income difference, there are no substantial differences in the labor participation and employment of whites and urban American Indiana aged 65+.

About half the urban American Indian population age 75+ lives with family members. American Indian families with elders in residence have three times the proportion of their population living in poverty as compared to whites. As Spero Manson has noted, generalizations about family support systems must be tempered with the knowledge that their resources are scare and irregular. Poverty increases the stress of care-giving.

HEALTH PROFILE

There is no comprehensive data base on urban American Indian health problems and health care needs. Indian Health Service collects no systematic data on diagnostic patient care from its urban health project providers. Nor does the National Center for Health Statistics and other sources have no data on urban Americans Indians.

The American Indian Physicians Association projects that American Indian elderly share the general health characteristics of the American Indian population at large. Obesity is common and is a risk factor for cerebrovascular disease, diabetes, cardiovascular disease and gall bladder disease. There is a high frequency of cataracts. Rheumatoid arthritis appears to occur with higher frequency than among non-Indians. High obesity, diabetes, cigarette use plus moderately elevated blood pressure and serum cholesterol are consistent with high cardio-vascular mortality and morbidity.

The information available on urban elders health was collected in surveys conducted through the auspices of American Indian organizations. In Phoenix 144 elders were surveyed in 1972, in Los Angeles a survey interviewed 328 elders in 1988, in a multisite survey the National Indian Council on Aging reported on 712 elders in 1981 and in Denver a survey on-going since 1987 has contacted 524 elders. The findings appear to be consistent. While responding with generally positive self-assessments on their

health, most elders suffered from health problems at the time of their interview.

The Los Angeles sample of respondents 45+ does not compare favorably on morbidity rates to either the national American Indian sample of elders aged 45+ or to the Cleveland general population sample of 65+ (Table 1). Los Angeles elders report higher frequencies of eye disease, speech pathologies, asthma, hypertension, cancer, stroke, amputation, diabetes, liver disease and cancer than American Indian elders nationwide. Similar complaints were noted for elders living in Phoenix where the most common health problems were diabetes, arthritis and rheumatism, hypertension, hearing problems and visual disorders.

In comparison to the general urban sample reported in Cleveland, American Indians in Los Angeles have dramatically higher frequencies of certain diseases. For instance, diabetes occurs 4.3 time more frequently and liver disease occurs 8.7 times more frequently. Hypertension was reported by nearly a third (30.7%) of the respondents aged 45+. Although no comparable data was collected by NICOA, the high frequency of dental problems was noted in Los Angeles as the third most frequently identified health problem.

NUTRITION

One small study on nutrition of urban elders was conducted in Lincoln Nebraska. Unlike their peers living on reservations, malnutrition was not found. However, both elderly whites and

American Indians in Lincoln were found to be below recommended levels in total food energy, vitamin A and calcium intakes.

UTILIZATION OF MENTAL HEALTH SERVICES

The low use of mental health practitioners by elderly American Indians indicates either less need than the general American Indian population or more selective barriers for this aging population. To some extent both of these variables interact. The positive role of "the elder" has been equated with the low incidence of self-destructive behaviors such as alcoholism and suicide. On the other hand, the notion of evaluating and treating mental health is highly stigmatized in the American Indian community.

There is no data on the mental health utilization patterns of urban elders. However, the reservation-based elders most frequent mental health complaint is anxiety and their most frequent physical complaints are for chronic illnesses. Stress has been associated with chronic disease and older urban American Indians were especially disadvantaged by their (and their health care providers) lack of awareness of psychological, social or economic resources which might ameliorate their conditions. When questioned, they expressed concern about "what people would think" if they solicited help.

Differences in life satisfaction between urban and reservation elders attending the second annual National Indian Council on Aging annual meeting, 1978. Greater dissatisfaction was expressed by urban elders and was associated with: 1) lack of planned

entertainment for American Indian senior citizens; 2) isolation; and 3) transportation problems. All are conditions which senior center activities and services would remedy.

ACTIVITIES OF DAILY LIVING

In the Los Angeles needs assessment the majority of respondents were not impaired in any Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL). However, the majority of those reporting impairments were unable to function independently in more than one ADL or IADL (Table 2). Age correlated with having multiple impairments. Those aged 60+ years tended to have more impairments (Table 3). Statistically significant differences between persons younger than 60 years and those older than 60 years occurred for transfer, mobility in the home, money management, shopping, transportation, meal preparation and light housework. The greatest number of impairments and the strongest relationships to age occur in the IADL categories.

Frail elders were receiving informal and formal assistance although in no case did the elder perceive that help to be sufficient. Although most elders in Los Angeles live alone or with a spouse, it is the frail community members who are found in large multigenerational households. Quite often unmarried grandchildren or children would be the care-givers. The extended family role in these cases is significant. However, accessing formal services may have been somewhat reduced. Until a crisis stage is reached, there may be little incentive to endure bureaucratic application

procedures and to receive supportive services. Furthermore, the eligibility requirements of some agencies may not support the extended family.

SUPPORT SERVICES

Urban American Indian elders are more likely than their reservation peers to rely on formal assistance programs. In Los Angeles, American Indian elders ranked their priorities for facilities, services and traditional activities which might be provided if an American Indian senior center was created. (Table 4) There was overwhelming approval for the establishment of a senior center.

ACCESS AND UTILIZATION OF TITLE III

I examined Management Information (MIS) reporting of Title III services for fiscal year 1989 in 18 Planning and Service Areas which have large concentrations of urban American Indians. One startling pattern emerged, suggesting that American Indians in the greatest social and economic need have not benefitted from Older Americans Act supportive services. Nine of the 18 areas investigated did not provide Title IIIc services in proportion with that percentage of the American Indian population aged 65+ living in poverty.

Arrayed in Table 5, is are the percentages of American Indians living in poverty at the 1980 US Census by region, compared to the percentage of that American Indian population over age 60+ served

by Title III. Unduplicated statistics were only available for comparing congregate meals. While we cannot know if those served were in poverty, clearly the areas with the lowest percentage of service cannot be reaching those elders in the greatest need.

The underlying causes and policies for this apparently uneven distribution of resources was beyond the scope of this research and remains unanswered. While American Indians generally represent less than 1% of the elderly population in any metropolitan area, allocation of resources based on an economy of scale is insufficient. Failure, for whatever reason, to serve an ethnic minority and those persons in greatest social and economic need, is hardly in keeping with the spirit of the Older Americans Act.

PROBLEM & SOLUTION

American Indian elders are considered a hard-to-serve population. A number of barriers reduce access to non-Indian health and supportive services. American Indians are not adept at cutting through the "white" tape and are unwilling to accept services delivered as charity. Distrust, lack of communication and cultural insensitivity too often characterize interactions between American Indian elders and non-Indian service providers.

I am not blaming the victim. Our society exhibits a systematic bias which few non-Indians seem to grasp. Over the next six months, you will become more aware of it. Sometime this soon, you will be watching professional, college or amateur sports and notice that one team is named after an ethnic group while most of

the rest are named after animals. In the fall, you might pick up your trusty savage rifle to go hunting and ask yourself if the caricature of an Indian improves the accuracy. Come Halloween there will be superheros and princesses and Indian braves. You won't see "Chinamen" or black face. Nor will you see other ethnic minorities represented as animals like you will on Thanksgiving cards where little bunnies and chipmunks invariably have feathered headbands. If you're lucky this Christmas we won't see any more of those battery-powered gorillas banging tom-toms. You may be the most receptive non-prejudiced person in this room, but you live in a society in which American Indians, as an ethnic group, are not treated like people. Add to this, the cultural perception of the elder who believes that our tone of voice and attitude are intolerably rude. We get right down to business before finding out who the person is we are dealing with and vice versa. I'm not saying that non-Indians cannot serve elders. I'm saying that elders must judge your trustworthiness against all odds.

There are successful solutions. Demonstration projects in Montana, Albuquerque and in Los Angeles have successfully linked elders to aging network services through peer group outreach programs. Information and referral alone is not sufficient to meet the multiple needs of frail American Indian elders. The case management approach taken by these outreach projects has been effective. In Los Angeles, 128 linkages to 47 agencies were effected. Without the outreach intervention by peer paraprofessionals, access to support services would not have

occurred.

American Indian staffing patterns are essential to overcoming cultural differences and systematic barriers. If adding additional staff is not a possibility, certainly coordination with local American Indian organizations is not precluded. The multipurpose urban Indian centers have developed staff positions for information and referral. The centers could be involved in outreach and follow-up as well as in advisory roles.

Finally, contracting Older Americans Act services with urban Indian centers dramatically increases the range of assistance available within the community. Indian centers are a significant node which attract a dispersed clientele. In Phoenix for instance, the center served (un unduplicated) 48 persons whereas the generic senior center meal sites served no more than two elders at any site. It is at this level that scale of services does seem to apply. It is hard to provide culturally sensitive activities for one or two persons at a congregate meal site. Overcoming the distances and dispersion of urban elders throughout a metropolitan area is a major challenge which Indian organizations have overcome in a number of locations.

TABLE 1. COMPARISON OF PREVALENCE OF MORBIDITY FOR SELF-REPORTED DISEASE OR SPECIFIC SYMPTOM BY PERCENT IN L.A. INDIANS 45+, NATIONWIDE INDIANS 45+, CLEVELAND GENERAL POP. 65+ AND U.S. GENERAL POP. 45+

HEALTH PROBLEM	L.A. 45+ (EXCEPT HOMELESS)	NATIONAL INDIAN 45+ *	CLEVELAND ALL RACES 65+ *	NATIONAL ALL RACES 45+ **
EYESIGHT	65.9	54.6	40.4	----
ARTHRITIS/RHEUM	36.4	42.6	41.9	26.9
HYPERTENSION	30.7	19.3	16.5	25.9
HEARING PROBLEMS	21.0	44.4	37.3	15.9
DIABETES	19.8	12.5	4.2	5.2
SLEEP PROBLEMS	17.0	30.4	33.5	----
HEART PROBLEMS	14.8	16.1	15.6	12.9
BREATHING PROB'S	13.1	34.0	23.0	----
ALLERGIES	12.0	----	----	9.0
HEADACHES	11.0	28.5	14.8	4.1
ASTHMA	8.1	4.3	3.2	2.8
STROKE	4.9	3.2	4.6	----
SPEECH PROBLEMS	4.6	1.4	1.2	----
LIVER PROBLEMS	3.5	1.6	0.4	----
KIDNEY STONES	3.2	8.9	1.9	----
MENTAL ILLNESS	3.2	7.9	4.4	----
AMPUTATION	2.8	1.2	2.1	----
CANCER	2.5	1.1	0.9	----
NUMBER OF MEN	99		687	
NUMBER OF WOMEN	184		1,037	
TOTAL NUMBER	283	712	1,834	

*NICOA, 1981
** US DEPT OF COMMERCE, 1988

Excerpted from Weibel-Orlando, J. & Kramer, B.J. (1989). The Urban American Indian Elders Outreach Project, final report of Administration on Aging demonstration project 90 AM0273, Los Angeles CA: County of Los Angeles.

TABLE 2. FREQUENCY OF IMPAIRED ACTIVITIES OF DAILY LIVING AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING BY AGE

ACTIVITIES	<60	60+	X^2
Bathing	6	16	(2,N=286)= 6.71, p=<.035
Dressing	5	12	(2,N=286)= 5.11, p=<.078
Toileting	4	10	(2,N=286)= 3.68, p=<.159
Transfer *	5	18	(2,N=284)=10.59, p=<.005
Feeding	2	5	(2,N=287)= 1.82, p=<.178
Mobility In *	9	28	(2,N=283)=14.65, p=<.001
Telephone	3	13	(2,N=294)= 9.15, p=<.010
Money Mgmt *	4	17	(2,N=290)=12.06, p=<.002
Shopping *	15	41	(2,N=294)=18.18, p=<.0001
Transport. *	15	41	(2,N=292)=20.35, p=<.0001
Meal Prep. *	13	31	(2,N=289)=12.20, p=<.002
Housework *	15	42	(2,N=290)=20.99, p=<.0001

Source: Kramer, B.J. (1990). Study of urban American Indian aging, presented at American society of Aging annual meetings, San Francisco.

TABLE 3. TOTAL NUMBER OF IMPAIRMENTS REPORTED IN ADL AND IADL

ACTIVITIES	<60	60=+	TOTAL
ADL	31	89	120
IADL	65	185	250
TOTAL	96	274	370

Source: Kramer, B.J. (1990). Study of urban American Indian aging, presented at American society of Aging annual meetings, San Francisco.

TABLE 4. PRIORITIES FOR AN AMERICAN INDIAN SENIOR CENTER

I. FIVE TOP RANKED OF 20 FACILITIES

FACILITY		% THINKS THIS IS VERY IMPORTANT OR IMPORTANT
Kitchen	(N=321)	97.8
Dining Room	(N=314)	97.5
Meeting Hall	(N=314)	96.8
Clinic	(N=306)	94.8
Powwow Hall	(N=308)	89.0

II. TEN TOP RANKED OF 17 TRADITIONAL ACTIVITIES

ACTIVITY		% WOULD USE	% WOULD HELP
Potluck Meals	(N=310)	90.3	8.7
Powwows	(N=305)	83.3	8.9
Craft Classes	(N=300)	80.0	12.3
Bingo	(N=106)	79.2	12.2
Indian History	(N=297)	77.4	9.4
Indian Storytelling	(N=289)	70.6	11.1
L.A. Indian History	(N=297)	68.7	7.2
Giveaways	(N=281)	67.6	5.7
Campouts	(N=281)	66.9	7.1

III. TEN TOP RANKED OF 33 GENERIC SERVICES FOR SENIORS

SERVICE		% WOULD USE	% WOULD HELP
Eye Examinations	(N=304)	91.1	1.6
Blood pressure Tests	(N=303)	89.4	2.2
Cardio-vascular Eval	(N=305)	87.5	1.6
Diabetes Screening	(N=300)	86.3	1.6
Field Trips	(N=145)	82.8	0.0
Legal Aid	(N=301)	80.4	3.3
Dental Care	(N=142)	79.6	0.0
Transportation	(N=303)	76.9	4.0
Exercise Class	(N=147)	76.9	0.0
Tax Assistance	(N=292)	73.3	4.4

Source: Kramer, B.J. (1990). Study of urban American Indian aging, presented at American society of Aging annual meetings, San Francisco.

TABLE 5
PERCENTAGE OF OLDER AMERICAN INDIANS LIVING IN POVERTY AND PERCENTAGE OF OLDER AMERICAN INDIANS SERVED BY TITLE III

U.S. REGION	% AMERICAN INDIANS 65+ BELOW POVERTY IN 1979[2]	% AMERICAN INDIANS 60+ SERVED BY PSA IN 1989[2]		AMERICAN INDIAN ELDERS IN PSA[3]
NORTHEAST	24.1	Boston	43.2	125 (0.13%)
		New York	4.53	1192 (0.09%)
MIDWEST	25.8	Milwaukee	30.77	273 (0.16%)
		Omaha	25.24	103 (0.17%)
		Chicago	17.84	438 (0.09%)
		Minn./St Paul	12.06	680 (0.26%)
		St. Louis	0.0	77 (0.07%)
SOUTH	28.8	Dallas	17.82	348 (0.20%)
		Oklahoma City	13.68	1477 (1.48%)
		Tulsa[4]	****	2955 (3.62%)
WEST	20.6	San Francisco	64.9	416 (0.30%)
		Oakland	62.09	401 (0.25%)
		Seattle	55.91	744 (0.40%)
		Denver	35.2	392 (0.22%)
		Los Angeles[5]	20.44	3572 (0.34%)
		Phoenix	7.59	1264 (0.52%)
		Albuquerque	6.59	728 (1.47%)
		Portland	1.57	318 (0.31%)

[2]Based on unduplicated MIS reporting of Title IIIc1

[2]Source Manson, S.M. (1988). Older American Indians: Status & issues in income, housing and health, presented at AARP conference, Toward Empowering Minority Elderly, St. Louis, Mo.

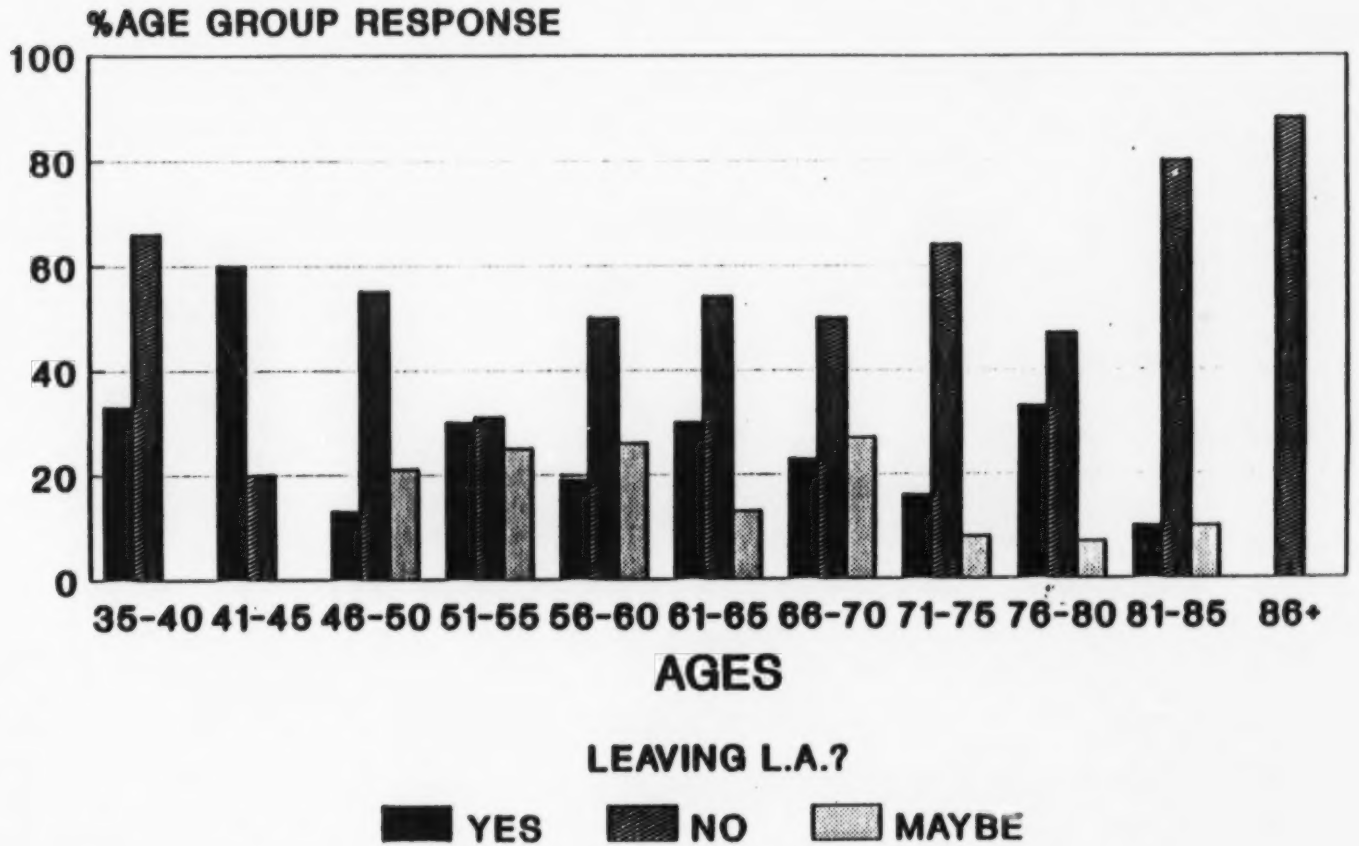
[3]Source: Bureau of the Census (1983). 1980 Census of Population and Housing: Census Tracts, PCH80-2. Washington DC: USGPO.

[4]Data not available

[5]Los Angeles County and City PSAs combined

FIGURE 1

GEOGRAPHIC STABILITY OF POPULATION PLANNING TO LEAVE LOS ANGELES?



N = 288

Source: Kramer, B.J. (1989). Study of Urban American Indian Aging. Presented at the annual meetings of the American Society on Aging, Washington, D.C.